

## EAR CONDITIONS (INCLUDING VESTIBULAR AND INFECTIOUS CONDITIONS) DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) **WILL NOT PAY OR REIMBURSE** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other: please describe

Are you a VA Healthcare provider?  Yes  No

Is the Veteran regularly seen as a patient in your clinic?  Yes  No

Was the Veteran examined in person?  Yes  No

If no, how was the examination conducted?

### EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

**SECTION I - DIAGNOSIS**

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN EAR OR PERIPHERAL VESTIBULAR CONDITION?

YES  NO (If "Yes," complete Item 1B)

1B. SELECT THE VETERAN'S CONDITION (check all that apply):

- |   |                 |                          |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Meniere's syndrome or endolymphatic hydrops  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Peripheral vestibular disorder   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Benign Paroxysmal Positional Vertigo (BPPV)  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic otitis externa   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic suppurative otitis media   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic nonsuppurative otitis media (serous otitis media)                            | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Mastoiditis  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Cholesteatoma  | ICD code: _____ | Date of diagnosis: _____ |
| <i>If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed</i>                           |                 |                          |
| <input type="checkbox"/> Otosclerosis   | ICD code: _____ | Date of diagnosis: _____ |
| <i>If checked, a Hearing Loss and Tinnitus Questionnaire must be completed in lieu of this Questionnaire.</i> |                 |                          |
| <input type="checkbox"/> Benign neoplasm of the ear (other than skin only)                                    | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Malignant neoplasm of the ear (other than skin only)                                 | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Other, specify: _____  |                 |                          |
| Other, diagnosis #1: _____  | ICD Code: _____ | Date of Diagnosis: _____ |
| Other, diagnosis #2: _____  | ICD Code: _____ | Date of Diagnosis: _____ |

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO EAR OR PERIPHERAL VESTIBULAR CONDITIONS, LIST USING ABOVE FORMAT:

**NOTE:** If the Veteran has hearing loss or tinnitus attributable to any ear condition **listed** above, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS (brief summary):

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

YES  NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THE DIAGNOSED CONDITION:

**SECTION III - VESTIBULAR CONDITIONS**

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING FINDINGS, SIGNS, OR SYMPTOMS ATTRIBUTABLE TO MENIERE'S SYNDROME (*ENDOLYMPHATIC HYDROPS*), A PERIPHERAL VESTIBULAR CONDITION OR ANOTHER DIAGNOSED CONDITION FROM SECTION 1?

YES  NO

IF YES, CHECK ALL THAT APPLY:

- Hearing impairment with vertigo  
If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly  
Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours
- Hearing impairment with attacks of vertigo and cerebellar gait  
If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly  
Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours
- Tinnitus, unilateral or bilateral  
If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly  
Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours
- Vertigo  
If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly  
Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours
- Staggering  
If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly  
Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours
- Hearing impairment and/or tinnitus  
If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.
- Other, describe: \_\_\_\_\_

**SECTION IV - INFECTIOUS, INFLAMMATORY AND OTHER EAR CONDITIONS**

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC EAR INFECTION, INFLAMMATION, CHOLESTEATOMA OR ANY OF THE DIAGNOSES LISTED IN SECTION 1?

YES  NO

IF YES, CHECK ALL THAT APPLY:

- Swelling (*external ear canal*)  
If checked, describe: \_\_\_\_\_
- Dry and scaly (*external ear canal*)
- Serous discharge (*external ear canal*)
- Itching (*external ear canal*)
- Effusion
- Active suppuration
- Aural polyps
- Hearing impairment and/or tinnitus  
If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed..
- Facial nerve paralysis  
If checked, ALSO complete Cranial Nerves Questionnaire.
- Bone loss of skull  
If checked, indicate severity:
  - Area lost smaller than an American quarter (*4.619 cm<sup>2</sup>*)
  - Area lost larger than an American quarter but smaller than a 50-cent piece
  - Area lost larger than an American 50-cent piece (*7.355 cm<sup>2</sup>*)
- Requiring frequent and prolonged treatment  
If checked, describe type and durations of treatment: \_\_\_\_\_
- Other, describe: \_\_\_\_\_

4B. DOES THE VETERAN HAVE A BENIGN NEOPLASM OF THE EAR (*other than skin only, such as keloid*) THAT CAUSES ANY IMPAIRMENT OF FUNCTION?

YES  NO

IF YES, DESCRIBE IMPAIRMENT OF FUNCTION CAUSED BY THIS CONDITION:

**SECTION V - SURGICAL TREATMENT**

5A. HAS THE VETERAN HAD SURGICAL TREATMENT FOR ANY EAR CONDITION?

YES  NO IF YES, INDICATE TYPE OF SURGERY:

Date: \_\_\_\_\_ Side affected:  Right  Left  Both

5B. DOES THE VETERAN HAVE ANY RESIDUALS AS A RESULT OF THE SURGERY?

YES  NO IF YES, DESCRIBE:

**SECTION VI - PHYSICAL EXAM**

6A. EXTERNAL EAR:

- Exam of external ear not indicated
- Normal
- Deformity of auricle, with loss of less than one-third of the substance  
If checked, specify side:  Right  Left
- Deformity of auricle, with loss of one-third or more of the substance  
If checked, specify side:  Right  Left
- Complete loss of auricle  
If checked, specify side:  Right  Left
- Other abnormality, describe:  
\_\_\_\_\_

6B. EAR CANAL:

- Exam of ear canal not indicated
- Normal
- Abnormal, describe:  
\_\_\_\_\_

6C. TYMPANIC MEMBRANE:

- Exam of tympanic membrane not indicated
- Normal
- Perforated tympanic membrane  
If checked, specify side affected:  Right  Left
- Evidence of a healed tympanic membrane perforation  
If checked, specify side affected:  Right  Left
- Other abnormality, describe:  
\_\_\_\_\_

6D. GAIT:

- Exam of gait not indicated
- Normal
- Unsteady, describe:  
\_\_\_\_\_
- Other abnormality, describe:  
\_\_\_\_\_

6E. ROMBERG TEST:

- Exam using this test not indicated
- Normal or negative
- Abnormal or positive for unsteadiness

6F. DIX HALLPIKE TEST (*Nylen-Barany test*) FOR VERTIGO:

- Exam using this test not indicated
- Normal, no vertigo or nystagmus during test
- Abnormal, vertigo or nystagmus during test, describe:  
\_\_\_\_\_

6G. LIMB COORDINATION TEST (*finger-nose-finger*):

- Exam using this test not indicated
- Normal
- Abnormal, describe:  
\_\_\_\_\_

**SECTION VII - TUMORS AND NEOPLASMS**

7A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

YES  NO

IF YES, COMPLETE THE FOLLOWING:

7B. IS THE NEOPLASM

BENIGN  MALIGNANT

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

YES  NO; WATCHFUL WAITING

IF YES, INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED (*check all that apply*):

Treatment completed; currently in watchful waiting status

Surgery

If checked, describe: \_\_\_\_\_

Date(s) of surgery: \_\_\_\_\_

Radiation therapy

Date of most recent treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Antineoplastic chemotherapy

Date of most recent treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Other therapeutic procedure

If checked, describe procedure: \_\_\_\_\_

Date of most recent procedure: \_\_\_\_\_

Other therapeutic treatment

If checked, describe treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

7D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (*including metastases*) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

YES  NO

IF YES, LIST RESIDUAL CONDITIONS AND COMPLICATIONS (*brief summary*):

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

**SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS**

8A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO

IF YES, DESCRIBE (*brief summary*):

8B. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (*6 square inches*); OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

YES  NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: \_\_\_\_\_ MEASUREMENTS: length \_\_\_\_\_ cm X width \_\_\_\_\_ cm.

**NOTE:** If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

8C. COMMENTS, IF ANY:

**SECTION IX - DIAGNOSTIC TESTING**

**NOTE:** If testing has been performed and reflects veteran's current condition, no further testing is required for this examination report.

9A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

YES  NO

IF YES, CHECK ALL THAT APPLY:

Magnetic resonance imaging (*MRI*) Date: \_\_\_\_\_ Results: \_\_\_\_\_

Computerized axial tomography (*CT*) Date: \_\_\_\_\_ Results: \_\_\_\_\_

Electronystagmography (*ENG*) Date: \_\_\_\_\_ Results: \_\_\_\_\_

Other, specify: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

9B. HAS THE VETERAN HAD AN AUDIOGRAM?

YES  NO

IF YES, ATTACH OR PROVIDE RESULTS:

**NOTE - IF THE VETERAN HAS HEARING LOSS OR TINNITUS, A HEARING LOSS OR TINNITUS EXAM MUST ALSO BE COMPLETED.**

9C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES  NO

IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (*brief summary*):

**SECTION X - FUNCTIONAL IMPACT**

10. DO ANY OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

YES  NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

**SECTION XI - REMARKS**

11. REMARKS *(If any)*

**SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE**

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

12A. Examiner's signature:

12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

12D. Date Signed:

12E. Examiner's phone/fax numbers:

12F. National Provider Identifier (NPI) number:

12G. Medical license number and state:

12H. Examiner's address: